Emergency Medical Services Advisory Committee
IDAPA 16.02.03.100

A statewide committee appointed by the Director of the Department of Health and Welfare "to provide counsel to the Department in administering the EMS Act"

**Meeting Dates**

EMSAC, June 30, 2005
Ameritel Inn-Boise Spectrum, 7499 Overland Rd., Boise, ID
EMSAC, Sept 22, 2005
Ameritel Inn-Boise Spectrum, 7499 Overland Rd., Boise, ID
**Call your regional EMS office for Information**

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IDAHO EMSAC News

EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE NEWSLETTER

# EMSAC response letter to National Scope of Practice Model draft #2

EMSAC members Vicki Armbruster, Lynn Borders, David Kim, Murry Sturkie and Ethel Peck met by teleconference on May 19, 2005 to develop a response letter to version 2 of the proposed National Scope of Practice Model. (This document may be viewed at www.emsscopeofpractice.org )

The National EMS Scope of Practice Model Task Force and the National EMS Scope of Practice Review Team will meet in mid June to review all comments received from across the nation. The review process will include one day devoted to hearing public input, with presenters having 10 minutes to address the review team.

Final recommendations from the National EMS Scope of Practice Model Task Force are due to the National Highway Traffic Safety Administration and the Health Resources Services Administration by the fall of 2005.

Thanks to all of the EMSAC members who participated and to Dr. Kim for compiling the first draft of the response letter. The letter was sent on May 23rd, along with a list of EMSAC members. Content of the letter follows:

> Thank you for the opportunity to review the second draft of the National EMS Scope of Practice Model and to offer comments. The following comments represent the consensus of the Idaho State EMS Advisory Committee (EMSAC). EMSAC is a broadly representative group of EMS stakeholders, created by Idaho statute. EMSAC assists the Idaho EMS Bureau in implementing the Idaho EMS Act by providing guidance and recommendations to the Bureau. A list of EMSAC members and their representation is enclosed.
>
> **General Comments:**
> Draft 2.0 is a significant improvement over 1.0, but we still have concerns about specific skills for specific providers, as described below. On the positive side, we believe that the proposed skills should allow both the EMT and Advanced EMT to complete a larger portion of interfacility transfers. This capability will be especially useful for the rural setting and for Critical Access Hospitals. We are also pleased to see certain OTC meds at the EMT level and limited pharmacological interventions at the Advanced EMT level.

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# National Registry testing the waters of change

EMSAC discussion concerning upcoming changes to National Registry certification focused on the proposed National Registry new written testing process to include computer based and Computer Adaptive Testing (CAT) and the limited availability of computer test

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**Inside this issue:**

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***EMSAC response letter to National Scope of Practice Model***

We agree with the decision to defer the Advanced Practice Paramedic to another venue, but request reconsideration of a Critical Care Paramedic level. Many ground EMS systems already utilize paramedics in a critical care role and we can expect to see increasing numbers of this type of EMS provider. Given its widespread utilization across state lines, we strongly support development of a national standard for the Critical Care Paramedic that can be rolled out with the new Scope of Practice Model.

## Specific Comments: Emergency Medical Responder (EMR)

Insertion of oropharyngeal airways is included in the EMR scope of practice (page 22, line 12). We recommend addition of nasopharyngeal airways for the EMR.

The list of EMR psychomotor skills seems to restrict unit-dose auto-injectors for hazmat situations (page 22, line 18). However, we don't see this restriction in the interpretive guidelines (page 30). We recommend clarification so that the EMR can carry an epinephrine auto-injector for acute allergic reactions, consistent with current Idaho practice.

The interpretive guidelines do not include "spinal immobilization" and "long board" for the EMR (page 29). We suggest adding this skill to the EMR.

## Specific Comments: Emergency Medical Technician (EMT)

We recommend adding oral antihistamines for acute allergic reactions at the EMT level.

To increase their ability to complete interfacility transfers, we recommend adding maintenance of a non-medicated IV to the EMT level.

We noticed that the EMT transports patients to an "appropriate medical facility" (page 23, line 17) while the other providers transport to an "acute care facility" (page 25, line 1 for Advanced EMT and page 26, line 40 for Paramedic). Is there a difference between these locations? In other words, can an EMT transport to a physician's office or other non-ED destination (urgent care, clinic, behavioral health center, etc), while an Advanced EMT or Paramedic can only transport to an ED? We recommend that clarification is made that allows non-ED transport by all transporting providers. We recognize that a non-ED patient destination may increase EMS system liability but would argue that this risk is out-weighed by improvement in EMS system performance, especially in the rural EMS setting where volunteer EMS personnel are taken out of service for prolonged periods of time to complete a transport to a distant ED. Non-ED patient destination should be an option for those EMS systems with active indirect medical oversight.

## Specific Comments: Advanced EMT

We recommend that the Advanced EMT be able to insert IOs.

We feel IM glucagon is rarely used in the field and suggest deleting glucagon (page 25, line 27) from the Advanced EMT. Since glucagon is the only medication intended for IM administration, elimination of glucagon will allow deletion of IM drug administration from Advanced EMT training.

## Specific Comments: EMT/Advanced EMT

Since both the EMT and Advanced EMT may utilize transport ventilators (page 23, line 32 and page 25, line 19), we recommend that these providers be able to recognize tension pneumothorax and perform needle chest decompression.

## Specific Comments: Paramedic

Does "percutaneous cricothyrotomy" (page 27, line 5) include the traditional surgical cricothyrotomy that is per-

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***EMSAC response letter to National Scope of Practice Model***

formed with a scalpel and trach hook? We recommend that paramedics be able to perform a surgical cricothyrotomy and not be restricted to percutaneous cricothyrotomy techniques.

The list of Paramedic psychomotor skills seems to imply that chest decompression can be performed by both needle and chest tube (page 27, line 6). However, the interpretive guidelines seem to restrict the Paramedic to needle decompression only (page 29). This should be clarified and we recommend that Paramedics be trained to insert chest tubes and not just monitor them. We recommend that paramedics be able to insert central venous lines.

The interpretive guidelines exclude the use of paralytics for paramedic intubation (page 29). We think this is a significant error. Given the current controversy over paramedic intubation, why deny them the tools to optimize their first-attempt intubation success rate? We strongly recommend adding "RSI with an induction agent and paralytic" to the Paramedic scope of practice.

The interpretive guidelines include "blood chemistry analysis" for Paramedics (page 29). This skill seems more appropriate for the critical care setting and a Critical Care Paramedic scope of practice. We recommend deletion of "blood chemistry analysis" from the list of Paramedic skills.

Once again, thank you for the opportunity to offer these comments on behalf of the Idaho Emergency Medical Service Advisory Committee. We hope that you will seriously consider them.

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*National Registry tries to reduce # of test sites*

sites.

Gregg Margolis, Associate Director of The National Registry of EMT's spoke to representatives of the Idaho Consortium for EMS Education on June 10th regarding the Registry's plans to implement computer based and CAT nationwide, beginning January 2007.

Gregg began by quoting from the Standards for Educational and Psychological Testing: "The primary purpose of licensure or certification is to protect the public." He also stated that "a good test is one that measures the candidate's ability to do the job."

He spoke on differences in test theories and described candidate performance as:

1. Can do the job and pass the test (True Positive)
2. Can do the job, but cannot pass the test. (False Negative)
3. Cannot do the job and cannot pass the test. (True Negative)
4. Cannot do the job, but can pass the test. (False Positive) (#1 Reason is cheating)

***"The Primary purpose of licensure or certification is to protect the public. A good test is one that measures the candidate's ability to do the job." Gregg Margolis***

CAT tests students at their ability level instead of with across the board difficulty levels. Because of this, students can complete a CAT test in as few as 75 questions or as many as 256 questions. As soon as a student proves their ability or inability, the computer will shut down. It is the standard for health professional testing for licensure and board exams. The main features of CAT are precision, accuracy and fairness. Since CAT tests students at their level of difficulty, students only see a fraction of questions compared to the current linear test which tests all levels of difficulty. The minimum score in each category will remain the same, only the delivery method will change.

Advantages for students will be the fact that they can make an appointment at a test center and take their test at their convenience instead of waiting for a specific day which is the current practice. Exam results will be available to the student the next day on the Registry website. A key benefit of the CAT is the elimination of false positives and theoretically a decrease in false negatives.

Potential disadvantages for the new Registry exam process is exam access and cost. Registry has contracted with the Pearson VUE Company to deliver the test. Current plans have limited options for test site locations, although additional sites are being explored in Idaho to provide candidates closer exam sites. The cost of the written exam will also increase, per exam attempt, as follows: First Responder from $20 to $65, EMT-B from $20 to $70, EMT-I 85 from $45 to $100, EMT-I 99 from $45 to $100, and Paramedic from $50 to $110.

More information on the National Registry computer based testing and CAT can be found on the NREMT website at http://www.nremt.org. The Idaho Consortium for EMS Education will continue to assist the EMS Bureau by investigating EMS certification testing options for Idaho EMS students.

# EMS goes to school

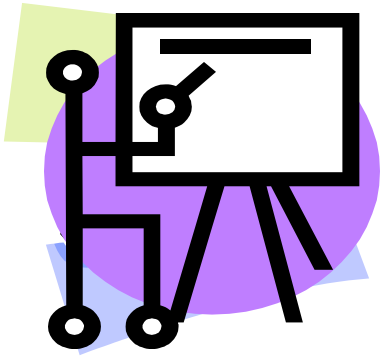
## Idaho Recruitment and Retention Training Program

The Education Sub-committee reviewed the new Idaho EMS Recruitment and Retention Training Program developed by Jeff Long of American Training Associates. Modeled after a program created by the State of Nebraska, the program was designed to assist volunteer EMS agencies develop agency specific EMS personnel recruitment and/or retention action plans.

The program includes such topics as Leadership Skills, Legal Considerations for EMS Agencies, Understanding the EMS Volunteer, Personality Differences, Motivating Others, Conflict Resolution and Communications. Additionally, templates for needs assessments, agency and volunteer surveys and action plans are included in the student handbook.

Funding from the Critical Access Hospital program enabled initial roll out of the program in May in Post Falls, Grangeville, Twin Falls and Idaho Falls. Each student receives a $200 stipend. The final course planned for this summer will be July 30th in Boise. If interested in attending this course at no cost please contact the EMS Office in Boise.

The lesson plans, Power point and student materials are available by request for use by any Idaho EMS agency. Please contact your EMS Regional Consultant if interested in these resources.



**Each student receives a $200 stipend.**

# Rule making process for Air Medical criteria gets off the ground

The Idaho State Legislature passed changes to section 56-1017 of the EMS code that became effective in July of 2004 requiring the EMS Bureau to engage the rule making process and develop "*criteria for the use of air medical services by certified EMS personnel at emergency scenes.*" A broad based statewide Task Force consisting of twenty-three (23) distinct stakeholders led the effort to construct criteria that will meet the needs of Idaho's EMS providers. After many meetings and much debate, the final draft is now on its way to the Administrative Procedures section for publication. We extend our thank you and appreciation to the Task Force members who labored so long and hard on this project.

Scheduled for publication in the August Administrative Bulletin, after August 3 you can download the proposed rules at http://www2.state.id.us/adm/adminrules/. A twenty-one (21) day open comment period will follow publication of the Administrative Bulletin. Following the comment period, the proposed rules will go to the Board of Health and Welfare in November and then the 2006 legislature for approval.

The draft *"Air Medical Utilization Criteria"* will be on hand at the EMS Bureau regional offices by July 1. EMS Regional Consultants statewide will lead the educational efforts and conduct orientation and outreach sessions for local EMS agencies. Please contact your Regional Consultant to schedule a discussion or address any questions you may have.

# Boise attendees call Rural Agency Administrator Quality Improvement Seminar a hit

Attendees at the first of three EMS agency Quality Improvement 2-day training seminars reported, **"I think every EMS Administrator should attend this class", "I'm excited to give it a try – a privilege to attend**", "**I think this program will be a big help to our organization"**. The kick off seminar for the series was held June 3-4 in Boise and will be repeated in July in Lewiston and August in Idaho Falls.

Incentives for attendees to attend both days of the seminar include a $200 check to their agency and the promise to administrators to take away advanced knowledge for Quality

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# EMSAC sub-committee, task force and advisory committee reports

## DISCIPLINARY

**Uncertified Responder:** The EMS Bureau was notified about an uncertified person responding to EMS calls. Although previously a student, the person was no longer in a training program and had not certified as an EMS provider in Idaho. A letter sent by the EMS Bureau to the associated EMS agency was reviewed. A motion was made recommending another letter be sent to the individual involved as well.

**Dispatch Delays:** A complaint was received by the EMS Bureau regarding delays in EMS response to a heart attack patient in a remote area of National Forest. Although the EMS Bureau has no jurisdiction over dispatch agencies, a motion was made by EMSAC to have the EMS Bureau send a letter to the county commissioners and dispatch center to ensure awareness of the complaint and suggest evaluation of their dispatch protocols.

**Ambulance Agency Complaint:** Allegations of inappropriate patient care by one EMS agency about another were unsubstantiated following review of patient care records and witness statements. No further action recommended.

## EDUCATION

EMT-I rules were passed during the 2005 Legislative session. Plans are being made for the first pilot programs.

## EMSC

Dr. Ken Bramwell, Wayne Denny and John Sanders visited the College of Southern Idaho to see a demonstration of the Sim-Man.

Future funding for the EMSC Program is still uncertain.

Over 300 people attended a Mother and Infants Seminar in Idaho Falls that educated participants on EMSC activities.

A family advocate representative position will be added to the EMSC subcommittee.

For purposes of data collection and analysis, a common definition for the pediatric population group is needed. Nationally, the ages of 0-21 are usually included, however in Idaho we are using the ages of 0-18. More research needs to be done to assist in assuring we are looking at a consistent age group for national comparisons.

## LICENSURE

- **Lincoln County EMS:** Motion was made to approve initial agency application for ILS Transport status, pending submission of revised protocols.
- **Tamarack Ski Patrol:** Motion was made to approve initial agency application for BLS Non-transport status, contingent upon revision of protocols to reflect only BLS skills, medications and procedures and an explanation of off-site transport plan.

## MEDICAL DIRECTION

Discussion concerning current draft version of Board of Medicine Rules centered the on-line medical direction at the EMS patient transport receiving facility. More discussion by the subcommittee was determined to be needed.

## Staff changes at EMS Bureau

Arrive Scene

**-Lisa Davidson: Region 6/7—Administrative Assistant**

**-Rachel Manning : Region 3/4 Administrative Assistant**

Depart Scene

**-Larry Carmona: Region 3/4 Regional Consultant**
**-Lori Powell: Region 6/7-Administrative Assistant**
**-John Sanders: EMSC Program Specialist**
**-Brenda Vasquez: Region 3/4 Administrative Assistant**

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***Quality Improvement Seminar***

Improvement in their agencies. While they may have been challenged, none were disappointed with the hands on approach used by Todd Hatley to present the "common sense" approach to Quality Improvement in EMS. As a provider, Todd brought the often daunting yet powerful concepts of quality improvement home for practical use in the EMS world. Todd authored the chapter titled "Using Data in Quality Management" in the recently published *Improving Quality in EMS.*

Seminar topics included an introductory overview of Six Sigma, Team Formation, Cost of Poor Quality, Defining Projects, Simple Graphical Tools & Exercises, Control Charts & Capability, Analysis, Probability & Statistics, Correlation, Improvement, Control, and Pilot Testing.

More information about a repeat of this Seminar to be held July 15-16 in Lewiston and August 12-13 in Idaho Falls is available for any agency administrator interested in attending. Contact your local EMS Regional Consultant for enrollment information.

**Emergency Medical Services Advisory Committee**

P.O. Box 83720
Boise, ID 83720-0036

***EMS Bureau Regional Offices***

*North— Jim Kozak*
*(208) 769-1585*
*North Central—Dean Neufeld*
*(208) 799-4390*
*Southwest—Doug Carrell (Temporary)*
*(208) 334-4633*
*South Central—Andy Edgar*
*(208) 736-2162*
*East—Scott Grunwell*
*(208) 525-7047*

IDAHO DEPARTMENT OF HEALTH & WELFARE

## EMSAC Membership

| NAME | REPRESENTING | E-MAIL ADDRESS |
|---|---|---|
| James Ackerman, Boise | EMT-Paramedic | boisemedic1@msn.com |
| Vicki Armbruster, Challis | Volunteer Third Service | ambulance@custertel.net |
| Lynn Borders, Post Falls | County EMS Administrator | Lynnb@kootenaifire.com |
| Kenny Bramwell, M.D., Boise | Pediatric Emergency Medicine | Kbramwell@emidaho.com |
| David Christiansen, M.D., Boise | Idaho Chapter of the Amer Academy of Pediatricians | christed@slrmc.org |
| Hal Gamett, Rigby | Fire department based non-transport | Hrg2@inel.gov |
| Kallin Gordon, Preston | EMT-Basic | Kallinkg@dcdi.net |
| Pam Humphrey, Pocatello | Air Medical | Pamh@portmed.org |
| Thomas Kraner, M.D., Boise | Committee on Trauma of the ID Chapter of American College of Surgeons | |
| Karen Kelli, McCall | Idaho Hospital Association | kkellie@mccallhosp.org |
| Mary Ellen Kelly, Meridian | State Board of Nursing | Marykell@sarmc.org |
| David Kim, M.D., Boise | Idaho Chapter of ACEP | boisedave@hotmail.com |
| Robert D. Larsen, Kellogg | Private Agency | |
| Warren Larson, Burley | EMS Instructor | Wjl@idahoems.com |
| Mary Leonard, Boise | (Acting) State Board of Medicine | Mleonard@bom.state.id.us |
| Scott Long, Idaho Falls | Idaho Fire Chief's Association | Slong@ci.idaho-falls.id.us |
| Cindy Marx, Sandpoint | Third service non-transport | Cindy@powine.com |
| Ethel Peck, Challis | Idaho Association of Counties | Custer@custertel.net |
| Ken Schwab, Driggs | County EMS Administrator | Kschwa@tetonvalleyhospital.com |
| Murry Sturkie, D.O., Boise | Idaho Medical Association | Emsdoc@cableone.net |
| Vacant | Career third service | |
| Vacant | Consumer | |

EMSAC Members may also be contacted through the State EMS Office (208) 334-4000